

Compliance Guidance~ Outpatient Diagnosis Reporting Advisory

Background

Selecting the most accurate ICD-9-CM diagnosis code to assign on an outpatient claim is a critical function; many services performed in a physician's office may be denied if the claim does not include the correct ICD-9 diagnosis codes as documented in the record. The advisory will address common inaccuracies and provide guidance. Information contained within is taken from Official ICD-9-CM Guidelines for Coding and Reporting (Coding Guidelines) and Medicare Claims Processing Manual. It is recommended that any clinic coding staff responsible for ICD-9 code assignment review this advisory.

Guidelines for Outpatient Diagnosis Coding and Reporting

The addressed guidelines are under four main categories.

1. Coding the Highest Degree of Specificity
2. Conditions or Symptoms Integral to the Disease
3. Primary (First-Listed) Diagnosis
4. Reporting Additional Diagnosis

Coding to the Highest Degree of Specificity

Both Coding Guidelines and Medicare require diagnosis codes to be reported to the most accurate degree of specificity. Medicare states, "Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable." This requirement infers that in some circumstances, a diagnosis code from a different category should be assigned **or** a series of codes should be used to completely describe the condition. Here are a few common examples that demonstrate this requirement.

⇒ Pneumonia and Influenza Vaccine Administration

Assign combination code V06.6 "Streptococcus pneumoniae [pneumococcus] and influenza" when administering both pneumonia and influenza vaccines during the same patient encounter.

⇒ Hypertensive Chronic Kidney Disease

When chronic kidney disease (CKD) and hypertension are both present, Coding Guidelines automatically assumes a 'cause-and-effect relationship' regardless if the provider links the two conditions in the documentation or not. Therefore, users are instructed to report a code from category 403 (Hypertensive chronic kidney disease) followed by the appropriate code from category 585 (Chronic kidney disease) to identify the documented CKD stage.

⇒ Diabetic Complications

Coding Guidelines does not assume a 'cause-and-effect relationship' for diabetes complications. In order for the correct coding sequence to be reported, the provider must first document a link between the patient's etiology condition (Diabetes) and the identified manifestation. Documentation such as "*diabetes complications: nephropathy*" or "*diabetic nephropathy*" would suffice as an established connection between the two illnesses. In these circumstances, ICD-9-CM code 250.0x "Diabetes mellitus without mention of complication" would not be reported. Instead, the

fourth (4th) digit would relate to the documented manifestation, followed by the code for the manifestation.

Documentation example: DM II with Diabetic Nephropathy

Diagnosis selection: 250.40, 583.81

Conditions or Symptoms Integral to the Disease

Coding Guidelines instruct users that, “Sign and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification”.

Example: Patient present to the clinic for “Follow-up on COPD management”. An appropriate history and exam are documented. The provider’s A/P includes the diagnoses; *Cough, Wheezing* and *COPD*. The patient is stable and the current medical management is continued.

Rationale: In this example, the patient’s “cough” and “wheezing” are considered integral to the disease process of COPD and should not be separately reported on the claim. The documentation is appropriate, only code 491.21 would be assigned.

Primary (First-Listed) Diagnosis

The primary diagnosis should relate to the documented reason for the service in the outpatient setting. Without this information the outpatient claim does not identify the correct diagnosis, condition or problem chiefly responsible for the service performed. Coding Guidelines for the outpatient setting states, “list first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided”.

Example: Patient presents for “follow-up, knee pain” a brief documented history outlines the patient’s acute right knee pain. A thorough, normal physical exam was performed. The documented plan of care addressed the patient’s current management of chronic conditions- hypertension, diabetes, and nocturia but the patient’s knee pain was not mentioned.

Rationale: In this example the E&M documentation is conflicting. The condition identified as the main reason for the encounter was not followed through in the remaining body of the note. The rest of the documentation does not link and instead relates to the patient’s chronic conditions with no correlation back to the initial reason for the visit. This kind of documentation does not identify which condition was “chiefly responsible for the services”. The documentation should be returned to the provider for clarification prior to primary diagnosis selection.

Reporting Additional Diagnosis

Any additional ICD-9-CM diagnosis codes reported on the claim must be documented and supported by the encounter’s documentation. Per Coding Guidelines, additional diagnosis may be reported if the documentation indicates that the conditions “coexist at the time of the encounter/visit, and require or affect patient care treatment or management”. It goes on to say that, “chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the condition(s)”.

Example: Patient presents to the clinic in follow-up for hypertension. The assessment and plan includes an additional diagnosis of ‘ulcerative colitis’ followed by a statement

to continue follow up with a different specialist. The ulcerative colitis is not mentioned anywhere else in the provider's clinical note for that date of service.

Rationale: For this example, the documentation did not provide enough information to determine if the patient's ulcerative colitis affects the treatment or management of the patient's care for that date of service. Also, the documentation did not indicate that the patient received treatment and care for the condition. Therefore an additional diagnosis for the ulcerative colitis should be not reported for that date of service. The coder may return the documentation to the provider for clarification prior to claim submission.

Conclusion

This advisory was designed to provide UCDHS professional coders with a brief reference of important Coding Guidelines related to the outpatient setting. We remind coders to always refer to the Coding Guidelines for outpatient services as well as the chapter-specific Coding Guidelines relevant to the documentation. Provider documentation is central to finding the right Coding Guidelines and, ultimately, accurate diagnosis codes.

"A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnosis and procedure that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved." – *Introduction, Official ICD-9-CM Guidelines*

Resources:

1. ICD-9-CM, Official ICD-9-CM Guidelines for Coding and Reporting, Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
 2. Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements
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Thank you for taking the time to review the information in this advisory.

If there are any questions, please contact:

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